August 19, 2004

November 15–16, 2004

December 1–2, 2004

January 25–26, 2005

Meeting Series Summary Report

July 8, 2005

Overview

In order to meet the National Cancer Institute (NCI) Director's Challenge Goal of "eliminating the suffering and death due to cancer," innovations in cancer care must be made available as efficiently as possible to the populations most in need. In longstanding recognition of this fact, the NCI has continuously worked to address barriers to rapid dissemination. There is broad consensus in the health community that significant gains can be achieved by improving rates of adoption of evidence-based approaches to cancer care. Yet, there is relatively little consensus—indeed, relatively little evidence—regarding how to improve the outcomes of requisite dissemination efforts. The literature reflects a number of perspectives on the problem and its potential solutions, but thus far, a comprehensive articulation of the necessary steps for improving dissemination to individuals, organizations, and complex social systems has not emerged.

The NCI sponsored the *Dialogue on Dissemination* meeting series as part of a larger effort to clarify the various concepts used to describe the translation of research into practice, develop models for effective dissemination, and close the gap between research discovery and program delivery. The *Dialogue* series brought together leading thinkers on the topic of dissemination to identify steps that might be taken—in the near term and over the long term—to improve the uptake of clinical and public health practices that are known to reduce the burden of cancer.

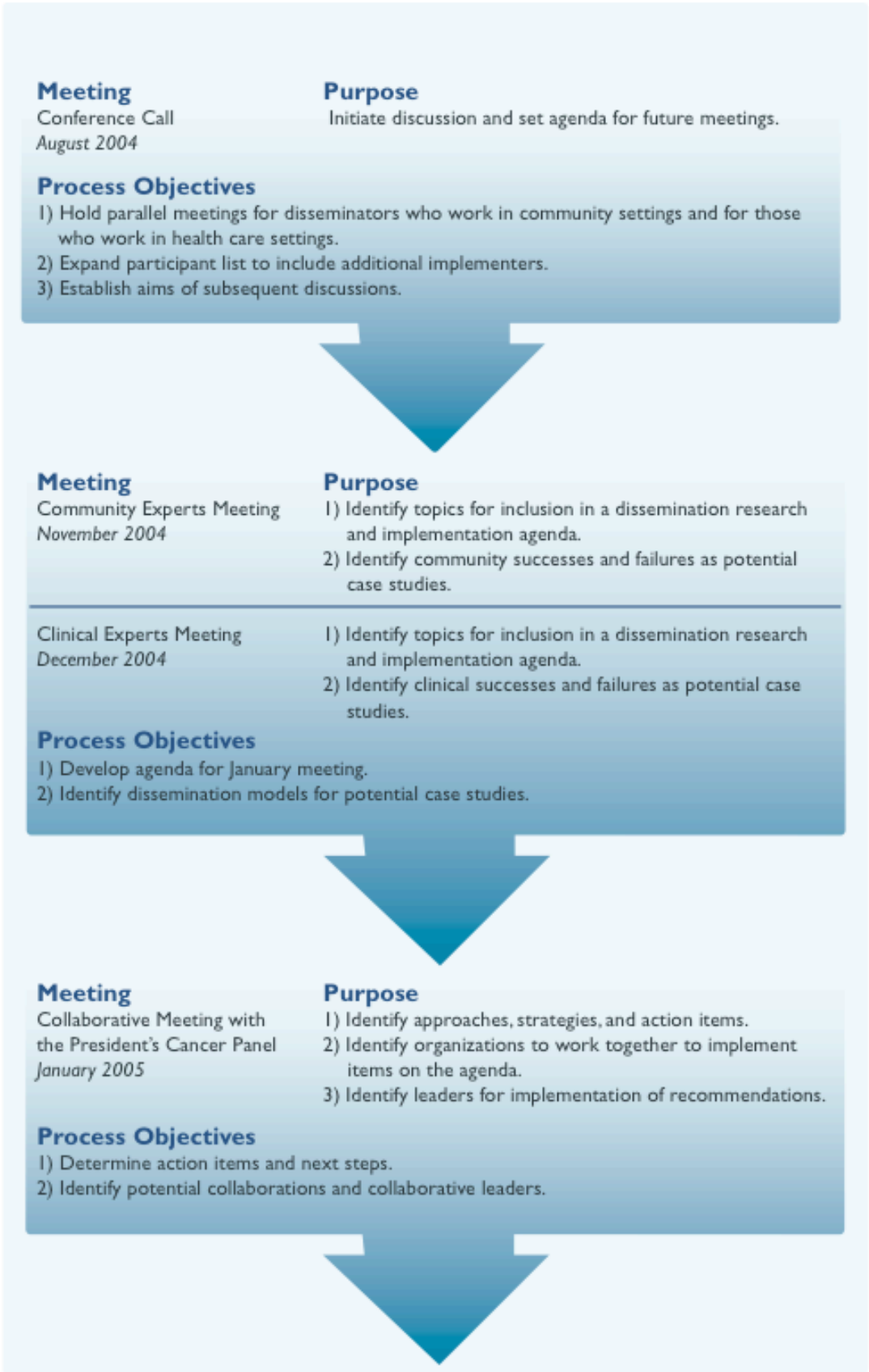
The *Dialogue* series produced a number of products. A comprehensive dissemination research and implementation agenda was created and revised over the course of three meetings. The agenda included recommendations for closing the development-to-delivery gap through key action steps in the areas of dissemination research and implementation. The necessary components of inter-organizational collaborations were detailed in the final meeting. Throughout the meeting series, case studies of successes were cited; the NCI is exploring the development and potential users of such case studies in support of dissemination models.

Dialogue participants and the organizations they represent will continue to advance the dissemination agenda by assuming a leadership role on a variety of action items. Products from the *Dialogue* series will be utilized in upcoming meetings sponsored by the NCI and made available to the public via the Information and Resources section of the Research Diffusion and Dissemination page of the NCI's Division of Cancer Control and Population Sciences (DCCPS) Web site.

Process

The *Dialogue* series was convened to enable the identification of prominent barriers and the generation of options for overcoming them, including immediate action steps to improve processes for accelerating the adoption of evidence-based practices. The series consisted of four meetings:

- August 19, 2004—Conference Call
- November 15–16, 2004—Community Experts Meeting
- December 1–2, 2004—Clinical Experts Meeting
- January 25–26, 2005—Collaborative Meeting with the President's Cancer Panel


Meeting
Conference Call
August 2004
Purpose
Initiate discussion and set agenda for future meetings.
Process Objectives
1) Hold parallel meetings for disseminators who work in community settings and for those who work in health care settings.
2) Expand participant list to include additional implementers.
3) Establish aims of subsequent discussions.
Meeting
Community Experts Meeting
November 2004
Purpose
1) Identify topics for inclusion in a dissemination research and implementation agenda.
2) Identify community successes and failures as potential case studies.
Clinical Experts Meeting
December 2004
1) Identify topics for inclusion in a dissemination research and implementation agenda.
2) Identify clinical successes and failures as potential case studies.
Process Objectives
1) Develop agenda for January meeting.
2) Identify dissemination models for potential case studies.
Meeting
Collaborative Meeting with the President's Cancer Panel
January 2005
Purpose
1) Identify approaches, strategies, and action items.
2) Identify organizations to work together to implement items on the agenda.
3) Identify leaders for implementation of recommendations.
Process Objectives
1) Determine action items and next steps.
2) Identify potential collaborations and collaborative leaders.

The series began with a conference call in August 2004 from which seven themes, two recommendations, and four potential products emerged. Based on the recommendations from the August 2004 conference call, the *Dialogue* participant list was expanded and face-to-face meetings of experts in the public health and clinical settings were held in November and December 2004, respectively. Facilitated small-group discussion at these meetings focused on developing a dissemination research and implementation agenda. Through discussions of key elements and challenges, effective tools, success stories, and immediate priorities, dissemination research and implementation agendas took shape. Due to overlap in the independently derived strategies and action steps recommended by community and clinical experts, a single, inclusive dissemination research and implementation agenda was produced.

A final face-to-face meeting in January 2005 was held in collaboration with the President's Cancer Panel (PCP) in order to share findings from the earlier meetings and develop an action agenda that the NCI and others in the cancer research and care community could use to improve the dissemination of evidence based products and practices for quality cancer care. The PCP monitors the progress of the National Cancer Program (NCP) through public hearings and issues progress reports and recommendations to the President of the United States each year. The 2005 PCP hearings focused on translating research into practice.

The collaborative meeting led to the identification of areas of overlap between recommendations generated from the *Dialogue* series and those gathered by the PCP through public testimony on *Translating Research to Reduce the Burden of Cancer*. In addition to identifying issues on which the *Dialogue* members and the PCP can leverage their resources to improve quality cancer care, the January meeting included small-group discussions on potential inter-organizational collaborations.

Insights garnered from the *Dialogue on Dissemination* series will be used by the NCI and shared with other organizations to improve the dissemination of research findings and evidence-based practices. The first opportunity to share these insights will occur during several Canada-United States meetings cosponsored by the NCI and the National Cancer Institute of Canada (NCIC) throughout the summer of 2005.

Background Material

Dialogue goals drew from earlier initiatives to understand dissemination. Participants were provided several documents before the first meeting, and were also offered the opportunity to share their work on dissemination or other literature that they found useful in developing their thinking.

Two reports and a meeting summary provided background information for *Dialogue on Dissemination* participants:

Diffusion and Dissemination of Evidence-based Cancer Control Interventions: Summary was issued by the Agency for Healthcare Research and Quality (AHRQ) in 2003. This summary was the result of a systematic review of dissemination-related studies initiated by the NCI and involving the AHRQ Evidence Practice Center at McMaster University. The overall finding of this report was that although efforts are underway to improve

dissemination, "the impact of these advances in cancer control research is limited by the failure to transfer new, evidence-based findings into widespread delivery …." (p. 1).

The AHRQ summary designated several areas and questions for future research. Areas for future research included: the importance of dissemination research focusing on the dissemination of evidence-based interventions, the need to define the role of nonrandomized trials in the field of dissemination research, the importance of defining outcome measures, and the need to reduce confusion around dissemination research terminology. Future research questions included: "What approaches can be undertaken to make dissemination and dissemination research a routine component of intervention research?" "What is the cost-effectiveness of different cancer control interventions and strategies to disseminate them?" "What is the role of new technologies in dissemination research?" "Can audit and feedback, local opinion leaders, and educational outreach be used to disseminate cancer control interventions?" and "What is the importance of local contextual barriers to effective dissemination of cancer control interventions?" The Summary concluded with a call for national agencies to lead the effort to improve dissemination research.

The *Designing for Dissemination* meeting was held September 19–20, 2002, in Washington, DC. Cosponsored by the NCI, Center for the Advancement of Health, and Robert Wood Johnson Foundation to examine the barriers to research dissemination and the adoption of evidence-based interventions, this meeting brought together 150 participants, equally representing the professional categories of researcher, practitioner, and policy maker. Preliminary findings from the AHRQ summary described above were shared with participants as background material. A pre-meeting concept mapping of responses to: "One thing that should be done to accelerate the adoption of cancer control research discoveries by health service delivery programs is …" revealed action steps needed in the areas of partnership and support, practice, policy, and research, with a strongly expressed need for intermediaries to facilitate the adoption process. Further examination of the concept mapping activity revealed disparities in the importance ranking of action steps among researchers, practitioners, and intermediaries, with only three action steps rated by all three professional categories as both highly important and highly feasible.

Designing for Dissemination attendees were divided into four groups—practitioners, researchers, Federal intermediary agencies, and non-Federal intermediary agencies—to develop group-specific action plans for accelerating the adoption of evidence-based practices. These plans included short- and long-term goals along with messages to other groups regarding requisite collaborative actions. A summary of all action plans can be found in the *Designing for Dissemination* meeting report under the "Final Report" link at http://cancercontrol.cancer.gov/d4d/info_d4dconf.html. The following suggestions were directed toward the NCI: designate more funding for dissemination research, encourage dissemination planning in grant applications, train study review sections on how to evaluate dissemination research, and provide a clear vision and more opportunities for collaboration.

Dissemination and Implementation of Evidence-Based Medicine: Barriers, Complexities and Strategies was prepared for the NCI by the University of Massachusetts Donahue Institute in 2004. This summary was the result of a narrative literature review focused on

identifying and understanding the barriers to implementation of evidence-based practices and identifying strategies for overcoming such barriers. Similar to the AHRQ summary, the report highlighted the need for clear definitions of terms related to evidence-based research and practice.

Among the problems identified with the dissemination and implementation of evidence-based medicine was the persistent research-to-practice gap, perceived costs associated with the adoption of evidence-based practices, system inertia, the challenge of creating change at the local level, and the overwhelming abundance of new information available on a daily basis. Other factors affecting the problem were the ignored impact of practical/tacit knowledge, lack of skills needed to implement research findings, and lack of assessment tools to determine quality clinical guidelines. Barriers and complexities associated with these problems were noted.

Strategies for addressing problems, barriers, and complexities in order to increase the implementation of evidence-based practices centered on the need for complex active diffusion strategies—with the caveat that with increased complexity comes increased cost. Strategic dissemination strategies such as continuing medical education (CME) and continuing professional development (CPD) were noted as having limited impact and lacking systematic evaluation despite their widespread use. While CME and CPD are potentially effective on the individual level, they cannot address system-level barriers that impede the implementation of new knowledge as it is gained. Multidisciplinary strategies were cited as having a higher level of effectiveness by not only providing knowledge and skills, but also setting the stage for system-level change. Comprehensive approaches that address gaps in care at all levels were presented as the most effective strategies. Examples of such approaches from the cancer field included strategies utilized by the NCI's DCCPS to address organizational barriers and the Quality in the Continuum of Cancer Care model that assessed and addressed all barrier categories. Specifically noted was the successful dissemination of evidence-based diabetes care which utilized the following key strategies: (1) establish a framework that highlights the necessity of evidence-based guidelines; (2) universally disseminate guidelines, along with educational and decision support programs to boost provider skills; and (3) measure the implementation of evidence-based guidelines using an audit-and-feedback system.

August 19, 2004, Meeting

The initial meeting in the *Dialogue on Dissemination* series (the August 19, 2004, conference call) brought together experts on the topic of dissemination to identify steps that can be taken to improve the uptake of practices known to reduce the burden of cancer. The majority of the call was dedicated to identifying elements of effective models of research dissemination that are currently either not well understood or not effectively put into practice. Each call participant shared a 5-minute PowerPoint presentation with the group, highlighting one or two of these missing, misunderstood, or misappropriated elements.

Seven themes emerged from the presentations and ensuing discussions:

- To enhance uptake, dissemination planning should begin early in the intervention development process.

- Understanding the needs of potential adopters is critical to understanding their motivation and subsequent actions related to evidence-based practice.
- In order to produce interventions that are valued by practitioners, the notion of "evidence-based" must be integrated with practical, "hands-on," tacit practice-based knowledge.
- Adoption of innovations is inherently influenced by organizational culture and local barriers.
- Efforts to drive dissemination and translation have placed too much emphasis on the researcher and not enough emphasis on the manager/user.
- There is a pressing need for dissemination research—i.e., research on how to effectively disseminate evidence-based innovations—in order to move into evidence-informed dissemination practice.
- There is a pressing need to realign the efforts of the organizations that fund intervention development and dissemination efforts.

Call participants also developed a plan for subsequent meetings. Recommendations were made to hold separate, context-specific, face-to-face meetings for experts in the community/public health and clinical fields, respectively, and to expand the participant group to include members whose primary responsibility is implementation.

Four products for the *Dialogue* series were defined:

1. A dissemination research agenda
2. A dissemination implementation agenda
3. An inter-organizational collaboration agenda
4. Case studies of successful and unsuccessful models of dissemination

November 15–16, and December 1–2, 2004, Meetings

Following recommendations of the August conference call, the *Dialogue* participant list was expanded, and separate face-to-face meetings were held November 15–16, 2004, and December 1–2, 2004, for community and clinical experts, respectively. Both meetings followed the same schedule: one day of small-group discussions on the necessary components of a dissemination research and implementation agenda and one half-day of large-group synthesis. Due to the high degree of overlap between the agendas outlined at the two meetings, a single, comprehensive agenda was created.

The comprehensive agenda was divided into two segments: dissemination research and dissemination implementation. To create a system that supports dissemination research, two broad action steps were identified: (1) build infrastructures; and (2) build a body of conceptual models, research methods, and theory-based approaches. To accelerate the implementation of evidence-based practices, two broad action steps were identified: (1) increase communication; and (2) promote partnerships. General strategies and specific action items were included within each of the four action steps.

Dissemination Research

Seven strategies and twenty-eight action items were detailed in order to address needs in the field of dissemination research.

Build Infrastructures

Strategy 1: Reconstruct and expand national funding mechanisms and requirements in order to accommodate the specific needs of dissemination and implementation research.

Summary of action items: Expand funding; include dissemination criteria in grant applications to force the consideration of dissemination potential early in the intervention development process; fund research-practice partnerships; and develop a surveillance system for monitoring the implementation of evidence-based approaches.

Strategy 2: Improve the quality of peer review for dissemination and implementation research.

Summary of action items: Orient and educate peer reviewers prior to distribution of applications for review and obtain feedback on the peer-review process from all parties.

Strategy 3: Examine and shift educational systems, educational approaches, and academic structures to provide incentives and rewards to increase training and career development in dissemination research.

Summary of action items: Expand funding for education and training programs; include dissemination potential in journal articles; encourage research-practice partnerships through academic rewards; and evaluate the impact of current educational efforts.

Strategy 4: Create a common lexicon of dissemination and implementation research methods and terminology.

Summary of action items: Increase understanding of the existing variations in terminology and identify a core set of outcome variables.

Build a Body of Conceptual Models, Research Methods, and Theory-Based Approaches

Strategy 5: Broaden and shift accepted research designs and methodologies.

Summary of action items: Shift from investigator-driven research to collaborative research involving research-practice partnerships and transdisciplinary teams; increase the value placed on quasi-experimental and natural observation research designs; increase the focus on system- and population-level change; study how to accelerate the slope of the diffusion-of-innovations curve through targeted, evidence-based dissemination efforts.

Strategy 6: Increase the study of specific areas of dissemination and implementation.

Summary of action items: Increase studies in the areas of systems approaches to dissemination, motivation, decision making, agents for change, dissemination channels, and contextual reinforcers and barriers.

Strategy 7: Capture evidence of progress and present it in ways that will be useful in considering new research strategies.

Summary of action items: Produce literature syntheses; compile a body of best practices; and make cost information available.

Dissemination Implementation

Five strategies and twenty-eight action items were detailed in order to address needs within the field of dissemination implementation.

Increase Communication

Strategy 1: Facilitate effective communication and interaction among all parties that can benefit from the translation of cancer control research findings into practice.

Summary of general action items: Conduct market research with providers and systems managers; emphasize the importance of team-based performance; communicate with senior managers about the value of evidence-based approaches; examine current initiatives for their value as case studies; and increase the value placed on integrating interpersonal connections and tacit knowledge with evidence-based practice.

Summary of research-practice partnership-specific action items: Create a glossary of terms for use within partnerships; determine the attributes of effective and ineffective partnerships; modify the academic reward system to encourage partnerships; reward partnerships in grant proposals while funding the organizational development necessary for sustainable change; and modify institutional review board policies to ensure that researchers can use and publish data collected through a partner's information systems.

Strategy 2: Make evidence-based practices and knowledge mobilization methods easier to adopt.

Summary of action items: Develop evidence-based guidelines that include practical considerations; develop or improve existing tools to make evidence-based practices easier to find and use based on current best practices of organizational change management; and develop mechanisms to assist organizations in creating adoption-related resources.

Promote Partnerships

Strategy 3: Promote partnerships between agencies that fund cancer control research and agencies that fund cancer control programs.

Summary of action items: Identify where collaborative dissemination processes are succeeding and failing; establish case studies of successful knowledge mobilization efforts; create a system of accountability for standards-based performance through funding agencies; increase funding to

support research-practice partnerships; develop best processes guidelines for establishing partnerships; and develop management information systems to enable practice partners to track their performance and evaluate the impact of interventions.

Strategy 4: Increase the demand for, and encourage a culture of, evidence-based practice within organizations that implement cancer control activities.

Summary of action items: Identify senior-level managers to serve as champions of evidence-based practice; establish knowledge brokers within organizations; increase team-based management approaches; encourage job modification based on evidence-based approaches; reward individuals and organizations that excel in the adoption of evidence-based practices; and develop a marketing initiative to increase the demand for evidence-based practices, paired with a supply to satisfy the ensuing demand.

Strategy 5: Cultivate dissemination partnerships based on mutual self-interest that can serve as conceptual models when appropriate.

Examples of such partnerships: A national exercise-clothing retail chain partnering with a national walking initiative; a school district renting space for community health activities; and media channels offering health programming. Overall, industry and professional associations can drive this effort by helping organizations understand the perceived self-interests of their constituents.

The integrated dissemination research and implementation agenda (summarized above*) was distributed to all *Dialogue* participants prior to the final meeting. Participants were asked to review the agenda in advance of the January meeting so that a feedback session could be held during the meeting.

*All suggestions for change to the agenda are reflected in the summary above.

January 25–26, 2005, Meeting

The culminating meeting of the *Dialogue* series was held January 25–26, 2005, in collaboration with the PCP. This final *Dialogue* meeting brought community and clinical experts together to accomplish four major tasks: (1) identify areas of overlap and opportunities for the leveraging of resources between the *Dialogue* and PCP; (2) achieve consensus on the dissemination research and implementation agenda; (3) identify the critical elements for an inter-organizational collaboration agenda; and (4) define next steps.

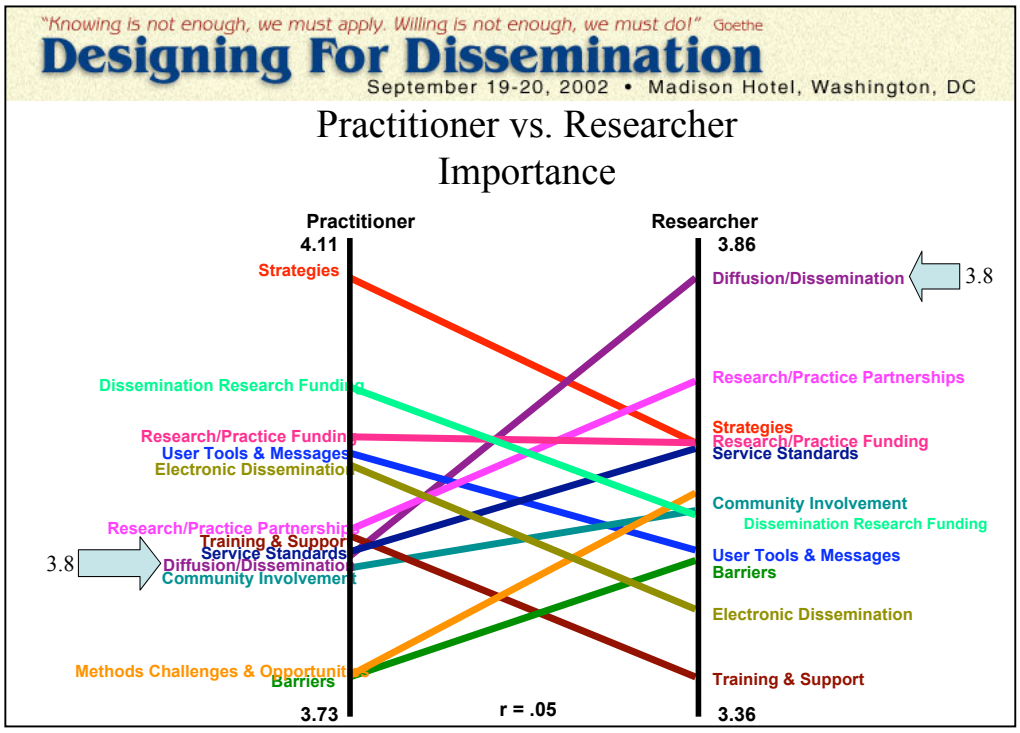
The January meeting commenced with a half day of presentations from representatives of the NCI and PCP, followed by discussion. The subsequent day consisted of small-group discussions focused on inter-organizational collaborations, followed by a large-group feedback session. The meeting concluded with an activity designed to assist participants in defining personal and organizational next steps.

Presentations

Jon Kerner, Ph.D.

Dr. Jon Kerner, Deputy Director for Research Dissemination and Diffusion, DCCPS, at the NCI, opened the meeting with a presentation highlighting select past efforts to understand and address the discovery-delivery gap. The presentation prominently featured the *Designing for Dissemination* meeting held in September 2002. This meeting brought together 150 participants—equally representing researchers, practitioners, and policy makers—to address the question of what can be done to accelerate the adoption of cancer control discoveries.

Designing for Dissemination included a concept-mapping exercise that indicated that the solution to the acceleration question could be found in four areas: Research, Practice, Policy, and Partnership and Support. All participants agreed that intermediaries with funding were needed to bridge the research-practice gap. Differences between researchers' and practitioners' responses were highlighted.



Dr. Kerner's presentation also highlighted a Canadian meeting at which the results of a study of agencies that fund research were reviewed. Discussion at this meeting revealed that the majority of methods utilized to incorporate research into practice are "push" methods. Dr. Kerner pointed out that in order to increase adoption, one must increase the demand for evidence-based practices.

Margaret Kripke, Ph.D.

Dr. Margaret Kripke, Member of the PCP and Executive Vice President and Chief Academic Officer of The University of Texas M. D. Anderson Cancer Center, followed with a presentation highlighting the findings from the 2004–2005 PCP series, *Translating Research to Reduce the Burden of Cancer*. Dr. Kripke shared that the PCP chose to focus

on translation because the progress made in laboratory research on cancer was not being matched by efforts to move this knowledge into practice. Recognizing the importance of continued focus on this topic, the PCP's 2005–2006 series, instead of focusing on a new topic, will bring together stakeholders to address recommendations made over the past 2 years regarding survivorship and translation.

Dr. Kripke's presentation focused primarily on the barriers that impede translation of discoveries from the laboratory to the clinic; these include research culture, infrastructure, funding, conflicts of interest, and the complexity of clinical trials. The importance of rewarding the work needed to translate a new discovery into a usable form was stressed, along with the need for more funding, increased infrastructure, and reduction in the complexity of enrolling in clinical trials. Problems associated with the increasing complexity of drug treatments, such as the difficulty of testing a drug combination involving products from different manufacturers, were highlighted. Dr. Kripke's presentation also highlighted barriers that impede dissemination from the clinic to the community: public trust, communication, community involvement, and cost. The necessity of involving the community early on in the research dissemination process was stressed, along with the need to create incentives for the delivery of quality care. Dr. Kripke concluded her presentation by sharing two potential recommendations from this year's PCP hearings: make dissemination an NCP funding priority and revise the Health Insurance Portability and Accountability Act (HIPAA) so that it does not impede clinical research.

Mark Clanton, M.D., M.P.H.

Dr. Kerner followed Dr. Kripke with a presentation created by Dr. Mark Clanton, Deputy Director for Cancer Care Delivery Systems at the NCI, who was unable to attend the meeting. Dr. Clanton's presentation highlighted the need for improved dissemination. The presentation began with an emphasis on the burden of cancer in the United States and the fact that the failure to disseminate information contributes to health disparities, since the bulk of translation efforts occur in academic centers, where a relatively small percentage of patients is seen. Examples of research-practice partnerships were provided, and the Cancer Control PLANET Web site was highlighted. The need for systems change was stressed, and several partnership models were featured: Chronic Care, the NCI-Food and Drug Administration collaboration, and the NCI-Centers for Medicare and Medicaid Services collaboration. Dr. Clanton's presentation ended with a reminder that dissemination, although not referred to by that term, has been a mandate of the NCI since its inception.

Question-and-Answer Session

A question-and-answer session focused on community issues followed. The ability to organize and empower a community to "pull" evidence-based treatments and overcome community barriers was discussed. It was observed that although community-level data are available, more data are needed, including community-level change markers. The point was raised that each community or community segment has a different capacity for change, thus requiring the use of individualized approaches and interventions. Systems and infrastructure were also discussed, with several participants calling for a reexamination of the entire cancer care system to better support and empower

community-level work. Dr. Kripke shared that the PCP will be recommending that the NCP increase its focus on and funding for dissemination, even if this requires a reduction in funding for other areas of research.

Lenora Johnson, M.P.H., C.H.E.S.

Ms. Lenora Johnson, Director of the Office of Education and Special Initiatives and Acting Director of the Center for Strategic Dissemination at the NCI, presented an overview of the integrated dissemination research and implementation agenda. Ms. Johnson discussed the 7 recommended strategies and 28 action items for advancing dissemination research and the 5 recommended strategies and 28 action items for advancing dissemination implementation. A feedback session followed, and the meeting was adjourned for the day. (Please refer to the summary of this document, which includes participant feedback, in the November and December Meetings section of this report.)

Inter-Organizational Collaborations and Next Steps

The second day of the January meeting was dedicated to the topics of inter-organizational collaborations and next steps. Three small groups, focusing on dissemination in the practice contexts of Prevention, Early Detection, and Treatment and Supportive Care, respectively, met in the morning to discuss inter-organizational collaborations in a context-specific manner. Each group developed a summary of its findings, and brief presentations were shared in a feedback session. Summaries of the small-group findings appear below.

Discussion Topic 1: What, if any, inter-organizational collaborations have proven particularly effective in dissemination efforts to promote the adoption of evidence-based (Prevention/Early Detection/Treatment and Supportive Care) options to date? What factors contribute to effective collaborations?

Small Group	Discussion Summary
Prevention	Examples included: 5 A Day Program; smoking cessation programs; United States Department of Agriculture (USDA) Cooperative Extension system; Centers for Disease Control and Prevention. Contributing factors included: trust; common goals/mission; inclusiveness; bridging the public and private sectors; involving the community; involving the three types of leaders (champions, implementers, and frontline people); face-to-face interactions; involving middle management; shared cultural context; utilization of the network model; researcher as consultant; creating sustainability.

Early Detection	Examples included: Cancer Center and community oncology collaborations; NCI–USDA partnership; Health Resources and Services Administration Heath Disparities Collaboratives; local support groups; patient navigation; mammography-based research and public hospital outreach, Maryland Colorectal Screening Program. Contributing factors included: trust; common goals; community will; organization within and by the community; nonhierarchical communication; holistic view of issues; strength focus; involving systems brokers; sharing resources, funding, and recognition; legal or political support; cost-effectiveness; flexibility in research; measurable goals; sustainability.
Treatment and Supportive Care	Examples included: Institute for Health Improvement Breakthrough Series; mental health; university and Government partnerships; extension and outreach systems within universities and communities. Contributing factors included: trust; community intermediaries; presence of content experts; measurable goals; leadership; specific interventions to meet needs; ability to solve problems; sociopolitical factors; economic factors; long-term commitment.

Discussion Topic 2: The Government, private for-profit, and nonprofit sectors each play a significant role in research, dissemination, and implementation of (Prevention/Early Detection/Treatment and Supportive Care) evidence-based interventions and outreach strategies. Would a centralized coordinating system be useful? If so, what would it look like, and what functions would it serve?

Small Group	**Discussion Summary**
Prevention	Features included: bottom-up network model; flexibility at local level; building upon existing systems; shared goals; coordinating hub with interconnected nodes; diverse expertise. Functions included: partnership development; capacity building; assessment of needs and assets; use of social network analysis.
Early Detection	Features included: local control; trust; clear goals; feedback mechanisms; voluntary participation; clearinghouse model; Web-based; coordination—but not central control—to avoid duplication; concern with culture; evidence- and experience-based approaches. Functions included: establishing linkages; provision of seed money; sharing the burden; establishing evidence and standards.
Treatment and Supportive Care	Features included: specific goals; wide range of participants; involvement of experts; working groups; coordinating council; involvement of existing organizations; prioritization of goals; clearinghouse model; feedback loop. Functions included: identifying and respecting local needs; data sharing; periodic reassessment of goals.

Action Steps

The January meeting closed with a session dedicated to action planning in order to advance the goal of closing the discovery-to-delivery gap. Participants utilized worksheets to designate dissemination research and implementation strategies (from the integrated agenda) in which they, personally, and their organizations might be willing to take a leadership role.

Approximately 60 percent of meeting participants identified next steps that either they or their organizations might be willing to undertake. Overall, there was more expressed interest in advancing dissemination implementation than in dissemination research, although this difference was slight. Of respondents, 65 percent expressed interest in continuing to work both personally and organizationally on strategies within both areas, and although not all strategies were equally popular, a minimum of two participants expressed interest in either personally or organizationally working to advance each strategy. For four strategies, ten or more participants expressed either personal or organizational interest.

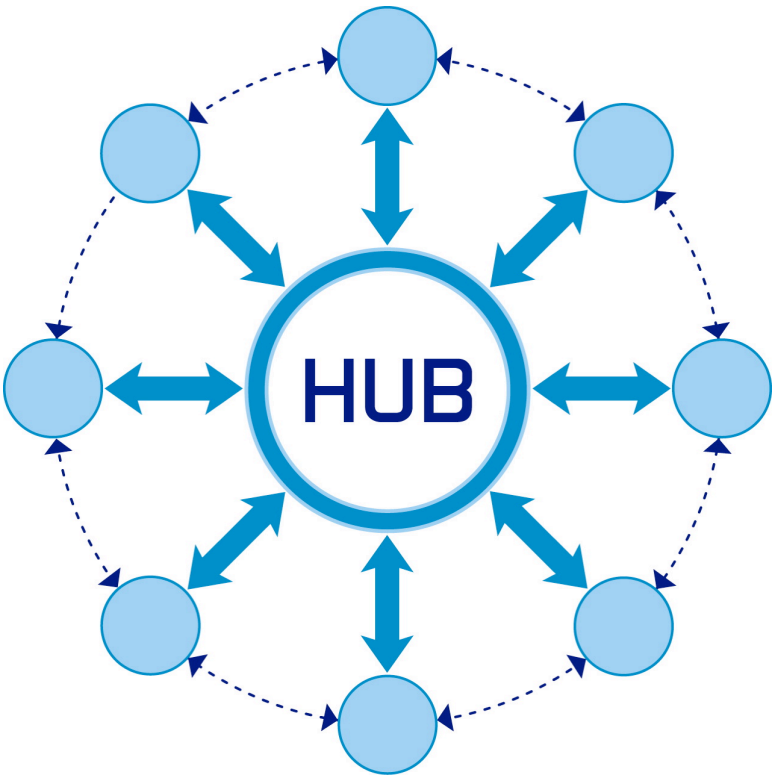
The strategies that drew the most interest were:

- Increasing the study of specific areas of dissemination.
- Promoting research-practice partnerships between funders of cancer control research and funders of service delivery programs.
- Cultivating broad-based dissemination partnerships based on mutual self-interest.

The strategies that drew the least interest were:

- Creating a lexicon of methods and terminology.
- Capturing current evidence of progress.

Results of the action planning survey were promising. They revealed a willingness amongst experts across the cancer care continuum to work both personally and organizationally to lead the advancement of dissemination research and implementation in order to reduce the burden of cancer. In addition, results indicated that experts representing diverse organizations are willing to share leadership with the NCI. This is consistent with the viewpoint expressed multiple times during the Inter-Organizational Collaborations discussions that a centralized coordination effort is needed that empowers others to lead.



Based on suggestions offered by various *Dialogue* participants, a centralized coordinating agency such as the NCI is needed to dispense financial and informational support to other key players. At the same time, local organizations must steer dissemination efforts within their communities in order to create buy-in and sustainable change. The entire coordinating system must have ample opportunity for feedback, evaluation, and modification of a uniting set of goals around which all work is centered.

Future Activities

Insights garnered from the *Dialogue on Dissemination* series will be used by the NCI and shared with other organizations to improve the dissemination of research findings and evidence-based practices. Several methods for sharing and advancing this critical information are in progress.

Web Site

Throughout the planning and implementation of the *Dialogue* series, a password-protected Web site was maintained. This site provided meeting information and allowed participants to share resources with one another. In order to make this information available to the widest possible audience, the content of the *Dialogue* site has been moved to the Research Diffusion and Dissemination page of the NCI's DCCPS Web site: http://cancercontrol.cancer.gov/d4d/info.html. This move makes available insights from the *Dialogue* series alongside those from related meetings, such as *Designing for Dissemination*. In addition, the NCI is reviewing the feasibility of establishing an online community to foster research-practice collaborations on specific partnership opportunities.

Upcoming Meetings

Insights from the *Dialogue* series will be utilized in three upcoming NCI-NCIC cosponsored meetings designed to bring together researchers and practitioners from both countries to focus on dissemination in the areas of public health, primary care, and oncology care. *Dialogue* recommendations will serve as a starting point for context-specific dissemination discussions. A concept-mapping process is planned, and action plans will be created to reduce the discovery-to-delivery gap for each content area.

Dialogue Participants

Dialogue participants will also continue to advance the dissemination research and implementation agenda. By assuming personal and organizational leadership roles on self-selected strategies, *Dialogue* participants will continue to close the development-to-delivery gap.

Case Studies

Throughout the *Dialogue* series, participants cited examples of programs they perceived to be strong examples of dissemination. The NCI is exploring the development of case studies in support of dissemination models.